

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

06315270

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County... TalbotCity or town... Denton, Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Buried Memorial Hosp Denton, Md

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Infant

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

6-3-47

8. AGE:

Years

Months

Days

If less than one day

1 mo

20

hrs.

min.

9. Birthplace

Caroline County, Denton, Md
(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

MOTHER FATHER

12. Name

Errett Breeding

13. Birthplace

Caroline County

14. Maiden name

Hazel Kemp

15. Birthplace

Talbot County

16. Informant

Errett Breeding

Address

Denton Md

17.

(Burial, cremation, or removal. Which?)

Date thereof

July 25, 1947
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

47

N. A. Nemes

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County Caroline

City or town

Denton Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

7-28-4719 47 at 6:45 P.

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6-319 47to 7-2319 47

and that I last saw him alive on

7-23-4719 47

Immediate cause of death

Due to

Atelectasis

DURATION

1 hr.

Due to

Due to

Prematurity

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

Not reported

Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

J. T. B. Ambler

M. D. or other

Address

214 E. Dover E. DentonDate signed 7/25/47

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JUL 28 1947
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Salisbury
 City or town Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 mos
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md. County Salbot
 City or town
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Delia Ann Callahan

3. (b) Social Security Number

4. Sex F 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Aug 22-1882 6.(c) If alive, give age _____ years

8. AGE: Years 64 Months 10 Days 17 If less than one day _____ hrs. _____ min.

9. Birthplace Ireland
 (Town, county, and state)

10. Usual occupation House wife

11. Industry or business

12. Name unknown

13. Birthplace

14. Maiden name unknown

15. Birthplace

16. Informant Mrs Margaret Schultz

Address Withman, Md

17. (Burial, cremation, or removal, Which?) burial Date thereof July 7/47

Cemetery or crematory Spring Hill Cemetery

Location Easton, Md.

18. Funeral director John D. Williams

Address Easton, Md

19. 7/8 47 N.H. Nevins
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 19 47 at 630 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 47 to July 4 19 47

and that I last saw her alive on July 3 19 47

Immediate cause of death Dilated DURATION 2 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury Injured at work?

23. SIGNATURE Myron Beale M. D. or other

Address Blum Date signed July 5 1947

MARGIN RESERVED FOR BINDING

(I)

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

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61

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

06311 290

1. PLACE OF DEATH:

County..... CalbotCity or town..... Easton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Separated

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

67Mrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

477/71947N. A. NeerunRegistrarEaston, Md.7/5/47

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

218-05-2074

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 319. 47

at

P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 28 1947 to July 15 1947and that I last saw him alive on July 15 1947Immediate cause of death Myocardialheart disease

DURATION

3 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 06312 290

1. PLACE OF DEATH:
 County Talbot
 City or town Easton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Nebraska Hospital, Easton, Md.
 How long in hospital or institution? 4 days 18 hrs 40 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Md. County Kent
 City or town Chesertown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 349 Cannon St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war World War I

3. (a) FULL NAME
Ernest Comegys

3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced single
 6. (b) Name of husband or wife
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) Jan. 1897
 8. AGE: Years 50 Months 7 Days If less than one day hrs. min.

9. Birthplace Kent Co., Md.
 (Town, county, and state)

10. Usual occupation farmer

11. Industry or business

FATHER 12. Name George Comegys
 13. Birthplace Kent Co., Md.

MOTHER 14. Maiden name Mary Bauer
 15. Birthplace Kent Co., Md.

16. Informant Eliak Comegys
 Address Kent Co., Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof 7/14/47
 (month) (day) (year)

Cemetery or crematory Chesertown
 Location Chesertown, Md.

18. Funeral director Leon W. Henry
 Address 310 South St. Easton

19. 7/14 19 47 N. H. Nevers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 July 19 47 at 1:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 July 19 47 to 10 July 19 47 and that I last saw him alive on 10 July 19 47

Immediate cause of death Cerebral Contusion DURATION 4 days

Due to trauma 6 July 47 9 days

Due to

Other conditions Fract. Comp. 4 days
Big 51 Fever
 (Include pregnancy within 8 months of death)

Major findings of operations. Date of op.

Autopsy results. PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Accident Date of 6 July 47

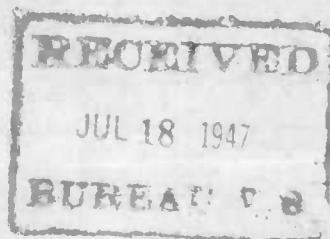
Where did injury occur? Forlows, Talbot Md.
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Harbourside

Means of injury 3 injured at work?

23. SIGNATURE J. F. Kennamer, M.D. M. D. or other

Address Easton, Md. Date signed 11 July 47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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06313

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Talbot County
 City or town Edenton, Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 24 hrs
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? 24 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Talbot
 City or town Staff, Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Mrs Elizabeth Davis

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Mrs Bradford Davis
 7. Birth date of deceased (mo., day, yr.) May 22, 1876 6.(c) If alive, give age _____ years
 8. AGE: Years 71 Months 2 mo Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Pennsylvania
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name Williams J. Seay13. Birthplace Conn14. Maiden name Geneva Buyer15. Birthplace Pennsylvania16. Informant Mrs Mary Martha BaughyAddress Querer St Egg Harbor N.J.17. Burial Date thereof July 24, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Reading TechLocation Rural, Egg Harbor, N.J.18. Funeral director Edwin ClarkAddress Edenton, Md19. 7/23 47 N.H. Neirin
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

EOT

20. DATE OF DEATH 7-22- 19 47 at 8:45 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 to 22 July 19 47and that I last saw him/her alive on 22 July 19 47Immediate cause of death Myocardial infarction -cardiac ruptureDue to Cerebral aneurysm

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations none done

Date of op. _____

Autopsy results none done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Phyllis Harrison M.D.Address Easton Maryland Date signed 23 July 47

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County 100400T

City or town EASTON Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Talbot

City or town Easton
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

JOHN LEMUEL FOSTER; John LEMUEL

3.(b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MALE WHITE MARRIED.

6.(b) Name of husband or wife ELIZABETH FOSTER

7. Birth date of deceased (mo., day, yr.) DEC. 9, 1890 6.(c) If alive, give age years

8. AGE: Years 57 Months 7 Days 13 If less than one day hrs. min.

8. Birthplace Queen Anne's Co.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name JOHN L. FOSTER

13. Birthplace Queen Anne's Co.

14. Maiden name MARGARET BALL

15. Birthplace Unknown

16. Informant CARL FOSTER

Address Easton Md.

17. Burial, cremation, or removal. Which? Burial Date thereof July 24, 1947
(month) (day) (year)

Cemetery or crematory Spring Hill

Location Easton Md.

18. Funeral director Carl Hofford

Address Easton Md.

19. 7/22 19 47 N.A. Neuman

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/22/1947 at 8 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1945 to July 22, 1947

and that I last saw him alive on June 10, 1947

Immediate cause of death

Arteriosclerotic Heart Disease

DURATION 5 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P.B. Cox M.D.

Address Easton Md Date signed 7/24/47

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JUL 28 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06316

Reg. Dist. No. 294

1. PLACE OF DEATH:

County Talbot CountyCity or town Tilghman
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Tilghman
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Edward A. Haddaway

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Ida Haddaway7. Birth date of deceased (mo., day, yr.) August 8, 1885.

6. (c) If alive, give age _____ years

8. AGE: Years 61 Months 11 Days 9 If less than one day _____ hrs. _____ min.8. Birthplace Tilghman, Talbot County, Md.
(Town, county, and state)10. Usual occupation Waterman11. Industry or business Oyster12. Name Varnon Haddaway13. Birthplace Tilghman, Md.14. Maiden name Margaret Cummings15. Birthplace Tilghman, Md.16. Informant Dalmus HaddawayAddress Tilghman, Md.17. Burial Date thereof 7/19/47.
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Tilghman M.E. CemeteryLocation Tilghman, Md.18. Funeral director J. Norman MarshallAddress St. Michaels, Maryland.19. July 19 1947 _____
(Date rec'd by registrar) _____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1947 at 5A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

now 1946, to July 15 1947and that I last saw him alive on July 16 1947Immediate cause of death Central Nervous SystemDURATION 6 hoursDue to hypertension strokeDue to arterio sclerosis 1/2

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

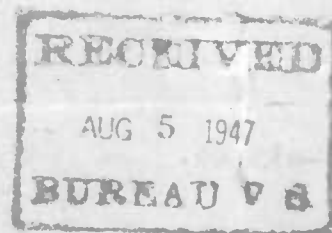
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Wm. P. PeaseAddress St. Michaels, Md. M. D. or other _____Date signed July 18/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06317

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Reg. Dist. No. 290

1. PLACE OF DEATH: Talbot
County.....
City or town..... Copperville, Eastern P.D.A. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... lifetime
Hospital, institution, or street address where death occurred:..... at home
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Maryland..... County..... Talbot
City or town..... Copperville (If outside city or town limits, write RURAL and give nearest town)
Street No..... R. F. D. -1 (If rural, give LOCATION)
2(a) If veteran, name war.....

3. (a) FULL NAME Willis Hinton
3. (b) Social Security Number

4. Sex Male
5. Color or race Colored
6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife Elizabeth Hinton
7. Birth date of deceased (mo., day, yr.) September 7, 1868
8. (c) If alive, give age..... years

8. AGE: Years Months Days If less than one day
78 10 6hrs.min.

9. Birthplace..... Copperville (Town, county, and state)
Farmer

10. Usual occupation.....

11. Industry or business.....

12. Name..... Samuel Hinton

13. Birthplace Talbot County

14. Maiden name Elizabeth Copper

15. Birthplace Talbot County

16. Informant Mrs. Maude Roberts

Address R. F. D. -1 Copperville, Md.

17. (Burial, cremation, or removal. Which?) 7/17/47
(month) (day) (year)

Cemetery or crematory..... Copperville

Location..... Copperville, Md.

18. Funeral director Leon W. Henry

Address 310 South St. Easton, Md.

19. 7/15-7/7 N.H. Neenan
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 14..... 1947..... at 12:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 44 to July 14 1947

and that I last saw him alive on July 12 1947

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Antopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

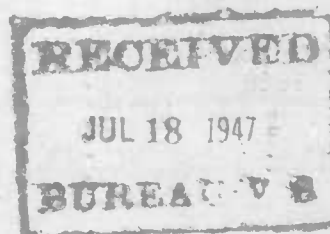
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

Address..... Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner's age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH:

County Talbot
 City or town St. Michaels
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Talbot
 City or town St. Michaels
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2(a) If veteran, name war _____

3. (a) FULL NAME

Sarah C. Hunt

3. (b) Social Security Number

none

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife William T. Hunt
 6. (c) If alive, give age 70 years
 7. Birth date of deceased (mo., day, yr.) Oct. 6, 1865
 8. AGE: Years 81 Months 8 Days 26 If less than one day _____ hrs. _____ min.
 9. Birthplace Queen Anne County
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business _____

FATHER 12. Name Frank Lowe
 13. Birthplace Talbot County
 MOTHER 14. Maiden name Mary A. Carvell
 15. Birthplace Queen Anne County
 16. Informant William T. Hunt
 Address St. Michaels, Md.

17. Burial Date thereof July 5, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Cemetery
 Location Stephensville Md.

18. Funeral director Newnam & Harrison
 Address St. Michaels, Md.

19. July 4 1947 Mrs. Robert L. Seth
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1st 1947, at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 23 1947, to July 1st 1947, and that I last saw her alive on July 1st 1947.

Immediate cause of death Branchio-pneumonia
 Due to Exposure

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE S. Dunning Willson M.D.
 M. D. or other _____
 Address St. Michaels Md. Date signed July 4/47

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THE MEDICAL SOCIETY OF MASSACHUSETTS

RECEIVED
JUL 7 1947
BUREAU # 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

153

06319

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:
County Talbot
City or town Easton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 days
Hospital, institution, or street address where death occurred:
Memorial Hosp. Easton, Md.
How long in hospital or institution? 26 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Queen Anne
City or town Centerville, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME
James Hynson

3. (b) Social Security Number

4. Sex M 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 21 - 1925 6. (c) If alive, give age _____ years

8. AGE: Years 22 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Queen Anne County
(Town, county, and state)

10. Usual occupation Farm labor11. Industry or business Father's Farm12. Name James Hynson13. Birthplace Queen Anne Co.14. Maiden name Martha E. Jones15. Birthplace Queen Anne Co.16. Informant James HynsonAddress Centerville, Md.17. (Burial, cremation, or removal, Which?) Burial Date thereof 7/16/47

(month) (day) (year)

Cemetery or crematory Burrsville, Md.Location Burrsville, Md.18. Funeral director Edgar L. LaneAddress Church Hall19. 7/15 19 47 N. L. Reeves

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 19 47 at 3 1/2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from birth 1947 to 14 July 19 47 and that I last saw him alive on 14 July 19 47

Immediate cause of death Acute disseminated lupus erythematosus

Due to erythematosus

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Antopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE James H. Hynson M.D.

Address Centerville, Maryland M. D. or other _____ Date signed 20 July 47

RECEIVED
JUL 23 1947
BUREAU 7 B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and correctly. It is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

06320

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Talbot
 City or town Longwoods Easton RD
 (If outside city or town limits, write RURAL and give nearest town)
 How long above place of death?
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)
 State md County Talbot
 City or town Longwoods
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Philip Lloyd Jenkins

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Col

6. (a) Single, married, widowed, or divorced

- 8 -

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 7-18-47
 6. (c) If alive, give age..... years

8. AGE: Years Months Days If less than one day

8 hrs. min.

9. Birthplace

Longwoods Talbot md
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

7/2747N. H. Neenan
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 19 47, at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Louis O. HodgeAddress Easton mdDate signed 7-29-47

Handwritten text, possibly a signature or address, at the top of the page.

Philip H. ...

RECEIVED
AUG 8 1947
BUREAU OF ...

Handwritten text at the bottom left of the page.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

06321

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County... TalbotCity or town... Easton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hosp. Easton, Md.

How long in hospital or institution?

3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... TalbotCity or town... Easton
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

FrancisJohnson

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife...

Margaret Johnson

7. Birth date of deceased (mo., day, yr.)

June 18, 1892

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

55 yrs1 mo10 da

hrs. min.

9. Birthplace...

Talbot County

10. Usual occupation...

Talbot collector

11. Industry or business

FATHER

12. Name...

Frank Johnson

13. Birthplace

Sweden

MOTHER

14. Maiden name...

Emma Johnson

15. Birthplace

Sweden

16. Informant...

Memorial Hospital

Address

Easton Md

17.

(Burial, cremation, or removal. Which?)

Date thereof...

Buried Aug 4, 1947
(month) (day) (year)

Cemetery or crematory...

Spring Hill

Location

Easton

18. Funeral director...

Starbuck

Address

Easton Md

19.

(Date rec'd by registrar)

19

8/247N.H. Nevers
Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH... July 31 19 47, at 12³⁰ A. M.

2T. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 26 19 47, to July 31 19 47and that I last saw him... alive on July 30 19 47

Immediate cause of death...

Coronary Thrombosis

DURATION

5 days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE... M. V. Palanga M.D.

M. D. or other

Address... Easton, Maryland Date signed... 8/4/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 06322 291

1. PLACE OF DEATH:

County... Talbot
 City or town... Bozman
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Laura H. Mc.Quay

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

female white married6. (b) Name of husband or wife... Robert J. Mc.Quay7. Birth date of deceased (mo., day, yr.) Oct. 15, 1866 6. (c) If alive, give age... 72 years8. AGE: Years Months Days If less than one day
80 8 23 hrs. min.9. Birthplace... Talbot County, Md.
(Town, county, and state)10. Usual occupation... Housewife

11. Industry or business

FATHER 12. Name... William Mc.Quay
13. Birthplace... Talbot County, Md.MOTHER 14. Maiden name... Arie Ann Ridgeway
15. Birthplace... Talbot County, Md.16. Informant... Robert J. Mc.Quay
Address... Bozman, Md.17. Burial Date thereof... July 11, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... CemeteryLocation... Bozman, Md.18. Funeral director... Newnam & Harrison
Address... St. Michaels, Md.19. July 10, 1947 Mrs. R. B. Smith
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Talbot
 City or town... Bozman
 (If outside city or town limits, write RURAL and give nearest town)

Street No.
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH... July 8, 1947 at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
March 6, 1947 to July 8, 1947
 and that I last saw her... alive on July 8, 1947

Immediate cause of death...
Cardiac Failure

DURATION

1 hr.Due to... Chronic Myocarditis10 yrs.Due to... Essential Hypertension15 yrs.

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Robert H. Brinkley M.D.
St. Michaels, Md. M. D. or other
 Address... St. Michaels, Md. Date signed... 7/10/47

RECEIVED

JUL 11 1947

BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

78d

CERTIFICATE OF DEATH

Reg. Dist. No. 06323

1. PLACE OF DEATH:

County... Talbot
 City or town... Easton Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 das
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? 6 das

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Talbot
 City or town... Easton Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... Route #2
 (If rural, give LOCATION)
 2.(a) If veteran, name war...

3. (a) FULL NAME

Miller, Eugene
 4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Single

3. (b) Social Security Number

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Unknown 1877 6. (c) If alive, give age... years

8. AGE: Years 70 Months Days If less than one day
hrs.min.

9. Birthplace... Talbot Co.
 (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

12. Name Joseph E. Miller13. Birthplace Unknown14. Maiden name Sallie Ann Christian15. Birthplace Md.16. Informant Mrs. J. B. BrooksAddress Easton Md17. Burial Date thereof 7/23/47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Spring HillLocation Easton Md18. Funeral director East Star Bur.Address Easton Md.19. 7/22 47 N. S. Norris

(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21st 19. 47 at 3:50 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16th 19. 47 to July 21st 19. 47and that I last saw him alive on July 21st 19. 47Immediate cause of death Allopathic reaction DURATION 1 1/2 yearsto transfusion 1 1/2 yrsDue to Nutritional Anemia

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

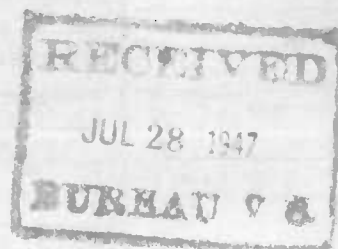
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William J. Seymour M. D. or otherAddress Easton Md. Date signed 7-24/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

06324

93d

1. PLACE OF DEATH:

County... TALBOT
 City or town... EASTON MD.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 50 years.
 Hospital, institution, or street address where death occurred:
Harrison St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... md County... Talbot
 City or town... Easton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Harrison St.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

ALONZA LEE NICHOLS.

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALE WHITE MARRIED.6. (b) Name of husband or wife... MARGARET NICHOLS.7. Birth date of deceased (mo., day, yr.) NOV 28 1870 6. (c) If alive, give age... years8. AGE: Years Months Days If less than one day
77 8 2 ...hrs. ...min.9. Birthplace... EASTON TALBOT Co. Md.
(Town, county, and state)10. Usual occupation... RETIRED.11. Industry or business... Stock dealer12. Name... HENRY NICHOLS13. Birthplace... TALBOT Co. Md.14. Maiden name... MARGARET WOOLEY.15. Birthplace... TALBOT Co. Md.16. Informant... MARGARET NICHOLS.Address... EASTON, MD.17. BURIAL Date thereof JULY 28, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... SPRING HILLLocation... EASTON TALBOT Co. MD.18. Funeral director... Carl W. StaffordAddress... Easton Md.19. 7/28 19 47 N.H. Neuner
(Data rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... 7/25/ 19 47, at 11:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 40, to 7/25/ 19 47
and that I last saw him alive on 7/25/ 19 47.

Immediate cause of death... DURATION

Arteriosclerotic Heart Disease 3 yearsDue to... Arteriosclerosis, Generalized 5 yearsDue to... Thrombosis, left 5 yearsOther conditions... Thrombosis, left

(Include pregnancy within 3 months of death)

Major findings of operations... Date of op. ...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

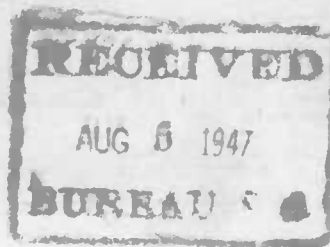
Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... J.B. Cox M.D.Address... Easton Md. Date signed... 7/29/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06325

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Talbot
City or town Easton R.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Talbot
City or town Easton Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Thos Vanneman Ranck

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife May Manner
6.(c) If alive, give age 73 years
7. Birth date of deceased (mo., day, yr.) Oct. 4 1874
8. AGE: Years 72 Months 9 Days 26 If less than one day hrs. min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)

10. Usual occupation Retired Editor

11. Industry or business Hearst Papers

12. Name Isaac Ranck

13. Birthplace Philadelphia, Pa.

14. Maiden name Harriet Vanneman

15. Birthplace Port Deposit, Md.

16. Informant Mrs. May Ranck

Address Easton, Md.

17. Burial Date thereof Aug 2 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Woodlawn

Location Port Deposit, Md.

18. Funeral director John D. Williams

Address Easton, Maryland

19. 7/31 47 N.H. Newer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30th 19 47, at 5:05 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 31 19 45 to July 30 19 47.

and that I last saw him alive on July 29 19 47

Immediate cause of death cerebral
apoplexy -

Due to cerebral arteriosclerosis

Due to Hypertrophied prostate 2 yrs

Other conditions Diabetes mellitus 4 yrs

(Include pregnancy within 3 months of death)

Major findings of operations Hypertrophied prostate

Date of op June 18, 1945

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Means of injury Injured at work?

23. SIGNATURE John F. Schneider, M.D. M. D. or other

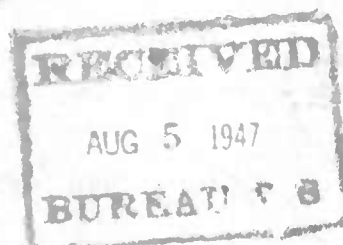
Address Easton, Md. Date signed July 30, 47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 290

1. PLACE OF DEATH:

County Tacket
 City or town Easton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 yrs.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Tacket
 City or town Easton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Joseph P. A. Richardson

3. (b) Social Security Number

715-07-5072

4. Sex M. 5. Color or race W. 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Sarah Louisa Richardson

7. Birth date of deceased (mo., day, yr.) May 17, 1882
 6.(c) If alive, give age 77 years

8. AGE: Years 65 Months 7 Days 7 If less than one day _____ hrs. _____ min.

9. Birthplace Tacket, Md.
 (Town, county, and state)

10. Usual occupation Electrician

11. Industry or business _____

12. Name Joseph Richardson

13. Birthplace Hagerstown

14. Maiden name Sarah Baker

15. Birthplace Ireland

16. Informant Mrs. Joseph P. A. Richardson

Address Easton, Md.

17. Burial, cremation, or removal, Which? Burial Date thereof July 22, 1947
 (month) (day) (year)

Cemetery or crematory Spring Hill

Location Easton, Md.

18. Funeral director W. H. Clark

Address Easton, Md.

19. 7/22 47 N. St. Niermes
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22, 1947 19 47 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____, to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death _____

Coronary occlusion

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Louis O'Harty M.D. Dep. Med. Dir.
Easton, Md. M. D. or other _____

Address _____ Date signed 7-22-47

RECEIVED

JUL 28 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

488

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2(a) if veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

8. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

47

N. H. Nevins

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 28, 1947

at 755 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 19, 46

to

July 28, 1947

and that I last saw him alive on

July 28, 1947

Immediate cause of death

Carcinoma of uterus

DURATION

1 yr.

Due to

Due to

Other conditions

Metastasis to umbilicus, lungs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Martin F. Buell M.D.

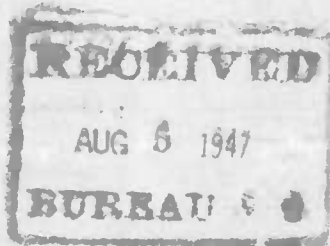
M. D. or other

Address

Easton Md

Date signed

7-29-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06328

Reg. Dist. No. 291

1. PLACE OF DEATH:

County TalbotCity or town St. Michaels
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town St. Michaels
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

W. James Thomas Jr.

3. (b) Social Security Number

4. Sex male 5. Color or race colored 6. (a) Single, married, widowed, or divorced widower6. (b) Name of husband or wife Lillie Thomas7. Birth date of deceased (mo., day, yr.) Dec. 5, 1884 5. (c) If alive, give age _____ years8. AGE: Years 62 Months 7 Days 9 If less than one day _____ hrs. _____ min.9. Birthplace Trappe, Talbot Co., Md.
(Town, county, and state)10. Usual occupation Gardner

11. Industry or business

12. Name W. James Thomas, Sr.13. Birthplace Trappe, Md.14. Maiden name Jane E. Jackson15. Birthplace Trappe, Md.16. Informant Sarah ThomasAddress St. Michaels, Md.17. Burial Date thereof July 16, 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory CemeteryLocation St. Michaels, Md18. Funeral director Newnam & HarrisonAddress St. Michaels, Md19. July 15, 1947 Mrs. Rex L. Beck
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14th 1947 at 4 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3 1947 to July 14 1947
and that I last saw him in alive on July 13th 1947Immediate cause of death Furunculosis
basin right leg DURATION 10 hrs.Due to arteriosclerosis
also chronic nephritis

Due to _____

Other conditions Hypertrophy of liver

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underlie the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE S. Denning Willson M.D.
M. D. or other _____Address St. Michaels Md Date signed 7/14/47

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 270

1. PLACE OF DEATH:
 County Bellevue
 City or town Boston, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 23 hrs 25 min.
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? 23 hrs. 25 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State New Jersey County Bloomfield
 City or town Bloomfield, N.J.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 21 Chestnut Terrace
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

John B. Vansant

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Luan S. Vansant
 7. Birth date of deceased (mo., day, yr.) April 1, 1865
 6. (c) If alive, give age 81 years
 8. AGE: Years 82 Months 2 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
(Town, county, and state)10. Usual occupation none

11. Industry or business

12. Name Thomas A. Vansant
 13. Birthplace Indiana
 14. Maiden name Edwina Pratt
 15. Birthplace Indiana

16. Informant Rev. Stephen E. Vansant
 Address 1501 Oakridge Place, Mount Airy, N.C.

17. Burial, cremation, or removal. Which? Removal Date thereof 7/4/47
 (month) (day) (year)
 Cemetery or crematory Bloomfield, N.J.
 Location Bloomfield, N.J.

18. Funeral director W. H. Clark
 Address Boston, Md.

19. (Date rec'd by registrar) 19 47 D. B. Neenan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13, 1947, at 11 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 July 1947 to 13 July 1947
 and that I last saw him alive on 13 July 1947

Immediate cause of death

Trauma to Cervical
Ford.Due to (Auto accident - 12 July 47)Due to (1947)

Other conditions

Arterio-sclerotic
Cardio-vascular disease
(Include pregnancy within 9 months of death)

Major findings of operations

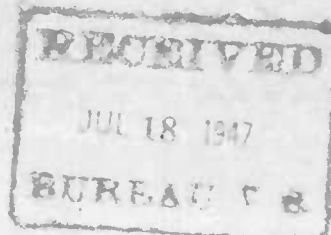
Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accidental Date of 12 July 47Where did injury occur? Near Denton, Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HighwayMeans of injury Auto Injured at work?23. SIGNATURE H. F. Kennamir M.D. M. D. or otherAddress Easton, Md. Date signed 15 July 47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

06330

CERTIFICATE OF DEATH

Reg. Dist. No. 270

1. PLACE OF DEATH:

County..... Talbot
 City or town..... Easton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 24 hrs.
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution?..... 24 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Charles
 City or town..... Denton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2(a) If veteran, name war.....

3. (a) FULL NAME

Baby Boy Wallace

3. (b) Social Security Number

4. Sex.....

m.

5. Color or race.....

col.

6. (a) Single, married, widowed, or divorced.....

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....

July 13, 1947

8. (c) If alive, give age..... years

8. AGE: Years..... Months..... Days..... If less than one day..... hrs..... min.

Infant9. Birthplace.....
(Town, county, and state)Easton, Talbot Co., Md.

10. Usual occupation.....

11. Industry or business.....

12. Name.....

Berd. Rayfield Wallace

13. Birthplace.....

unknown

14. Maiden name.....

Rose Linterfield

15. Birthplace.....

unknown

16. Informant.....

Rose Wallace

Address.....

Denton, Md. RD #2

17. (Burial, cremation, or removal. Which?).....

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. (Date rec'd by registrar).....

7/14/4747N.H. Reurus
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 14 19..... 47 at 8:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 13 19..... 47 to July 14 19..... 47and that I last saw him..... alive on July 13 19..... 47

Immediate cause of death.....

DURATION.....

Due to.....

Prematurityper asphyxiation

Due to.....

Due to.....

Due to.....

Due to.....

Due to.....

Due to.....

Due to.....

Due to.....

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

58c

CERTIFICATE OF DEATH

06331
Reg. Dist. No. 290

1. PLACE OF DEATH

County... Salbot
City or town... Easton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 days

Hospital, institution, or street address where death occurred:

Memorial Hospital Easton MdHow long in hospital or institution? 33 days

3. (a) FULL NAME

Anna Delicena Miles Williams

4. Sex

F

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Oct. 18, 1930

6. (c) If alive, give age..... years

8. AGE:

Years	Months	Days	If less than one day
<u>16</u>	<u>8</u>	<u>20</u>hrs.min.

9. Birthplace

St. Michaels

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

FATHER

12. Name... H. Washington Miles13. Birthplace... St. Michaels

MOTHER

14. Maiden name... Gladys Williams15. Birthplace... Rayle Oak, Md.16. Informant... Mrs. Gladys WilliamsAddress... St. Michaels, Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof... July 19, 1947

(month) (day) (year)

Cemetery or crematory... CemeteryLocation... St. Michaels, Md.18. Funeral director... Newnam & HarrisonAddress... St. Michaels, Md.19. 2/18

Date rec'd by registrar

19. 47

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... SalbotCity or town... St. Michaels
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH... July 16 19 47, at 7 45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

23 May 19 47 to 16 July 19 47and that I last saw him/her alive on 16 July 19 47Immediate cause of death... Cerebraledema

DURATION

Due to... Rheumatic MyocarditisDue to... 3 MonthsOther conditions... Kidney failure

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... W. Herbert HarrisonAddress... St. Michaels, Md.Date signed 24 July 47

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH CB

06332

Reg. Diat. No. 290

1. PLACE OF DEATH:

County Salisbury
 City or town Easton, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 1/2 hours
 Hospital, institution, or street address where death occurred:
Memorial Hospital of Easton
 How long in hospital or institution? 7 1/2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Delaware County Kent
 City or town Wyoming - Route #1
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war. _____ ✓

3. (a) FULL NAME

Charles Zach

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Mrs. Louise Zach (wife)
 6.(c) If alive, give age 56 years
 7. Birth date of deceased (mo., day, yr.) April 6, 1891
 8. AGE: Years 56 Months 3 Days 6 If less than one day _____ hrs. _____ min.

9. Birthplace Zovavos, Czechoslovakia
 (Town, county, and state)

10. Usual occupation Butcher

11. Industry or business Farmer

12. Name Charles Zach

13. Birthplace Zovavos, Czechoslovakia

14. Maiden name Anna Zich

15. Birthplace Zovavos, Czechoslovakia

16. Informant Mrs. Louise Zach

Address Wyoming, Delaware - Route #1

17. Buried Date thereof July 15, 47
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Episcopal Dover

Location Dover, Del.

18. Funeral director J. Harry Williams

Address Federalburg MD.

19. 7/15-47 Registrar W. H. Newell

(Date reg'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 19 47 at 11:35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____, to _____ 19 _____

and that I last saw him alive on _____ 19 _____

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. H. Newell M. D. or other M. D.

Address Easton Md. Date signed _____

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JUL 18 1947

SERIAL 8